

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-046288

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 74 Primary Registration District No. 4136 Registrar's No. 1

FILED JAN 10 1963

1. PLACE OF DEATH a. COUNTY <u>Clinton</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Clinton</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Plattsburg</u>		c. CITY OR TOWN <u>Plattsburg</u>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>R. D. 1</u>		d. STREET ADDRESS (If outside, give location) <u>R. D. 1</u>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Merle</u> Middle <u>V.</u> Last <u>Divelbiss</u>		4. DATE OF DEATH Month <u>December</u> Day <u>31</u> , Year <u>1962</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>1/1/1894</u>
9. AGE (last birthday) <u>68</u>		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during past 12 months, e.g., retired) <u>Rural Mail Carrier</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Post Service</u>	
11. BIRTHPLACE (City and state or country) <u>Hempfle, Missouri</u>		12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>	
13a. FATHER'S NAME <u>Sam Divelbiss</u>		13b. MOTHER'S MAIDEN NAME <u>Sarah Williams</u>	
14. NAME OF HUSBAND OR WIFE <u>Iva Divelbiss</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>yes</u>	
16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT Address <u>Mrs. Iva Divelbiss, Plattsburg, Mo.</u>	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Coronary Heart Disease</u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		INTERVAL BETWEEN ONSET AND DEATH <u>10 mins.</u> <u>1+ yr.</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)		20c. TIME OF INJURY Hour <u> </u> a.m. <u> </u> p.m. <u> </u> Month, Day, Year <u> </u>	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20f. CITY, TOWN, OR LOCATION		COUNTY	
20g. STATE		21. I attended the deceased from <u>12-31-62</u> to <u>12-31-62</u> and last saw him alive on <u>12-31-62</u> Death occurred at <u>7:15 AM</u> on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE <u>PT Luckenhill MD</u> (Degree or title)		22b. ADDRESS <u>Plattsburg, Mo.</u>	
22c. DATE SIGNED <u>2 Jan, 1963</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	
23b. DATE <u>1/2/1963</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Brethren Cemetery</u>	
23d. LOCATION (City, town, or county) <u>Plattsburg, Missouri</u>		24. FUNERAL DIRECTOR <u>Lyon Funeral Home, Inc, Plattsburg,</u>	
25. DATE RECD. BY LOCAL REG. <u>Mo 1-10-63</u>		26. REGISTRAR'S SIGNATURE <u>Harold W. M. D.</u>	

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK
OR
TYPEWRITER RIBBON

JAN 15 1963

JAN 10 1963

MAR 28 1963

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Philip E. Cox

Licensed Embalmer No. 4998

P. O. Address Clatsburg, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.